

The UCN at the top of the Criminal Justice Consent is incorrect. It is displaying a UCN that is associated with a client that is only in the D7 Agency, regardless of the client that the consent is created from. The UCN in the footer is correct. This issue has been sent to FEi.

**AUTHORIZATION FOR RELEASE OF INFORMATION
CRIMINAL JUSTICE REFERRAL**

Legal Last Name Christmas	First Name Father	MI	Date Of Birth 6/29/1970
Other Names Used			Unique Client Number 101021484981100

I, **Father Christmas** authorize **SUD Administrative Agency** to release, use, receive, mutually exchange, communicate with and disclose to **MH Administrative Agency** the following information:

The purpose of the disclosure authorized herein is to Test and to inform any person, entity, or agency listed above of my attendance and progress in treatment.

By placing my initials in the spaces below, I specifically understand that the following highly confidential information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization:

HIV/AIDS ____ Mental Health ____ Alcohol/Drug ____ Genetic ____ STD ____ TB ____

I have read this authorization/had this authorization read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will. I understand that this authorization will allow my treatment team to plan and coordinate services I need, to impose appropriate sanctions or rewards based on my behavior and will also allow any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I further understand that some or all of this information may be discussed in open court, a public forum, where any person in the courtroom may hear the information. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

I understand that this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. I also understand that if I do not comply with treatment, my non-compliance will be reported to the judge and the prosecuting attorney/deputy attorney. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

Requested Willingham, Robert, Test Facility 1 of 2 Confidential and Proprietary
Criteria: Client Name = Father Christmas // Client Id = 10629170000006A // Agency Name = SUD Administrative Agency // Intake Facility = Test Facility // Case Number = 1